

MEDICAL HISTORY QUESTIONNAIRE

STERLING EYE CENTER, L.L.P.

220 S. 3rd St., Suite 1, Sterling, CO 80751 - 970-522-1833 or 800-331-3711

JOHN E. ELLIFF, M.D./WILLIAM S. BUCHANAN, M.D.

TODAY'S DATE: _____

PATIENT NAME: _____ SEX: ___ AGE: ___ DATE OF BIRTH: _____

FAMILY PHYSICIAN: _____

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any yes answer.

Current eye problem or reason for visit: _____

OCULAR HISTORY

Have you ever had any eye disease, surgery or injury? NO ___ YES ___

If yes, please describe including dates and the name of the doctor who treated you.

Date	Doctor	Description
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_____	_____	_____
_____	_____	_____

Have you ever worn glasses or contact lenses? NO ___ YES ___

If yes, how old is your glasses or contact lens prescription? _____

MEDICAL HISTORY

Have you ever had surgery anywhere on your body, in your whole life? NO ___ YES ___

If yes, please describe: _____

MEDICATION

Please list any medication you currently take, *prescription and over-the-counter*.

Do you have any allergies to medications? NO ___ YES ___

If yes, please list medications: _____

SOCIAL HISTORY

With your current glasses or contact lenses, does your vision make it difficult for you to :

Read? NO ___ YES ___

Write? NO ___ YES ___

Drive? NO ___ YES ___

Cook? NO ___ YES ___

Sew? NO ___ YES ___

Watch TV? NO ___ YES ___

Work? NO ___ YES ___

Do you:

Smoke? NO ___ YES ___

Chew Tobacco? NO ___ YES ___

Drink Alcohol? NO ___ YES ___

Use Drugs? NO ___ YES ___

REVIEW OF SYSTEMS

Do you have any problem in the following areas? If yes, please explain.

Cancer NO ___ YES ___ - _____

Diabetes NO ___ YES ___ - _____

Thyroid NO ___ YES ___ - _____

High Blood Pressure NO ___ YES ___ - _____

Lungs/Breathing NO ___ YES ___ - _____

Heart Disease NO ___ YES ___ - _____

Tuberculosis NO ___ YES ___ - _____

Headaches NO ___ YES ___ - _____

Skin NO ___ YES ___ - _____

Genitals, Kidney, Bladder NO ___ YES ___ - _____

Bones, Joints, Muscles NO ___ YES ___ - _____

Blood (HIV positive, Hepatitis) NO ___ YES ___ - _____

Psychiatric NO ___ YES ___ - _____

FAMILY HISTORY

Has *ANYONE* in your family besides you (such as, parents, grandparents, siblings, children) had any of the following?

Cancer NO ___ YES ___ WHO: _____ TYPE: _____

Tuberculosis NO ___ YES ___ WHO: _____ TYPE: _____

Diabetes NO ___ YES ___ WHO: _____ TYPE: _____

High Blood Pressure NO ___ YES ___ WHO: _____ TYPE: _____

Heart Disease NO ___ YES ___ WHO: _____ TYPE: _____

(Such as: heart attack, stint, angioplasty, by-pass surgery, hardening of arteries)

Eye Disease NO ___ YES ___ WHO: _____ TYPE: _____

(Such as: glaucoma, macular degeneration, cataracts, retinal detachment, lazy eye)

Patient or legally authorized signature

Date

Relationship (parent, legal guardian, personal representative, etc.) _____